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### BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

ALLEN AGAPAY, M.D.

Holder of License No. **24148**For the Practice of Allopathic Medicine
In the State of Arizona.

Board Case No. MD-07-0273A

# FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER

(Letter of Reprimand and Probation)

The Arizona Medical Board ("Board") considered this matter at its public meeting on February 6, 2008. Allen Agapay, M.D., ("Respondent") appeared before the Board with legal counsel Stephen A. Bullington for a formal interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue the following Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

## FINDINGS OF FACT

- The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.
- Respondent is the holder of License No. 24148 for the practice of allopathic medicine in the State of Arizona.
- 3. The Board initiated case number MD-07-0273A after receiving notification of a malpractice settlement involving Respondent's care and treatment of a sixty year-old male patient ("RR"). RR was seen at a hospital emergency room on August 28, 2000 for abdominal pain and fever. The emergency room physician ordered an abdominal CT scan which noted the presence of a left renal mass. Respondent examined RR, diagnosed appendicitis and performed surgery on August 29, 2000. The surgery included an open appendectomy with exploratory laparotomy,

drainage of intraabdominal abscess, sigmoid resection and Hartmann procedure with descending end colostomy.

- 4. Although prior to surgery Respondent was aware that an abdominal CT scan was performed, Respondent never spoke with the radiologist regarding the CT scan and he never reviewed the CT scan or CT report during the course of RR's hospitalization. The Board expressed concern regarding Respondent's entries in the hospital record referencing the CT scan in that the entries indicate that Respondent had spoken with the radiologist. Respondent testified that, in fact, he received the information that he documented regarding the CT scan from the emergency room physician.
- 5. The CT report was transcribed on August 31, 2000 and placed in the medical records maintained by Respondent's office. Although RR was seen three times in Respondent's office for follow-up after the surgery, Respondent never reviewed the CT report reflecting the renal mass. Respondent testified that he was on vacation when RR initially followed up in his office and that an associate saw RR. Respondent testified that, perhaps during that time, the CT report came into his office and due to an office error it was placed in the file without his review or initials. Respondent testified that his office practice is for him to review every report that comes in to the office and to initial the report before it is placed in the patient file.
- In 2003, approximately three years after the surgery, RR was diagnosed with end stage renal cancer and subsequently died.
- 7. The standard of care requires a surgeon to be aware of the results of a CT scan either by personal review or by discussion with the radiologist. The standard of care also requires review of reports in the hospital and office charts.
- 8. Respondent deviated from the standard of care by failing to review the CT scan directly or the interpretation of the scan with the radiologist, resulting in a delay in diagnosis of

over three years of a potentially curable renal cell carcinoma which resulted in the death of the patient.

# CONCLUSIONS OF LAW

- The Arizona Medical Board possesses jurisdiction over the subject matter hereof and over Respondent.
- 2. The Board has received substantial evidence supporting the Findings of Fact described above and said findings constitute unprofessional conduct or other grounds for the Board to take disciplinary action.
- 3. The conduct and circumstances described above constitutes unprofessional conduct pursuant to A.R.S. § 32-1401(27)(q) ("[a]ny conduct or practice which is or might be harmful or dangerous to the health of the patient or the public).

## <u>ORDER</u>

Based upon the foregoing Findings of Fact and Conclusions of Law,

#### IT IS HEREBY ORDERED:

- Respondent is issued a Letter of Reprimand for failing to review an abdominal CT scan and/or subsequent report.
  - Respondent is placed on probation with the following terms and conditions:
- a. Respondent shall obtain 20 hours of Board Staff pre-approved Category I Continuing Medical Education ("CME") in medical ethics to be completed within six months. The CME hours shall be in addition to the hours required for biennial renewal of his medical license. The probation will terminate when Respondent supplies proof of course completion satisfactory to Board Staff.
- 3. Respondent shall obey all federal, state, and local laws and all rules governing the practice of medicine in Arizona.

4. In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

## RIGHT TO PETITION FOR REHEARING OR REVIEW

Respondent is hereby notified that he has the right to petition for a rehearing or review. The petition for rehearing or review must be filed with the Board's Executive Director within thirty (30) days after service of this Order. A.R.S. § 41-1092.09(B). The petition for rehearing or review must set forth legally sufficient reasons for granting a rehearing or review. A.A.C. R4-16-103. Service of this order is effective five (5) days after date of mailing. A.R.S. § 41-1092.09(C). If a petition for rehearing or review is not filed, the Board's Order becomes effective thirty-five (35) days after it is mailed to Respondent.

Respondent is further notified that the filing of a motion for rehearing or review is required to preserve any rights of appeal to the Superior Court.

DATED this day of April 2008.



THE ARIZONA MEDICAL BOARD

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ORIGINAL of the foregoing filed this day of April: 2008 with:

Arizona Medical Board

LISA S. WYNN Executive Director

1	9545 East Doubletree Ranch Road Scottsdale, Arizona 85258
2	Executed copy of the foregoing
3	mailed by U.S. Certified Mail this day of April: 2008, to:
4	Stephen A. Bullington, Esq. Jones, Skelton & Hochuli, PC
5	2901 North Central Ave., Suite 800 Phoenix, Arizona 85012-2703
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7	Allen Agapay, M.D. Address of Record
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